

NEW JERSEY STATE BOARD OF MEDICAL EXAMINERS

VASCULAR SURGERY

Vascular Surgery Procedures

PRIVILEGE CRITERIA

1. Attestation (Attachment 1 - in attestation format provided)

I am demonstrating clinical experience by attesting, in Attachment 1, to the number and type of procedures in vascular surgery which I performed in the last two years with acceptable results for patients of all age groups, except age groups specifically excluded from my practice, **plus** through additional material below.

2. Training (Attachment 2A)

I am providing, as Attachment 2A, documentary evidence of **one** of the following:

(1) Current certification in vascular surgery granted by the American Board of Surgery with general vascular surgery certification or the American Osteopathic Board of Surgery with general vascular surgery certification or any other certification entity that is demonstrated by the applicant to have standards of comparable rigor **OR**

(2) Successful completion of an ACGME/AOA accredited residency training program in vascular surgery, **OR**

(3) Supervised training in residency or fellowship or other equivalent experience in _____ (**another field**) **AND** active participation in examination process leading to certification in vascular surgery.

3. Record Review/Clinical Observation (Attachment 3 - in format provided):

References - Names, addresses and specialty, residency or observation only

I am providing, as Attachment 3, the names, addresses and specialty of three plenary licensed physicians who will directly submit references addressing my current competence based on their personal knowledge obtained either during a residency training completed during the two years preceding the date of this application or through personal observation during the two years preceding the date of this application.

4. Log of procedures (Attachment 4A, for each privilege requested - in format provided)

I am providing, as Attachment 4, a **separate log** listing all patients for whom, in an office setting or licensed ambulatory care facility setting during the two years preceding

Licensee Name: _____ License Number: _____

the date of the application, I performed each of the procedures for which I am requesting privileges. The log includes a patient number, the type of anesthesia service provided, the surgery or special procedure performed and the date(s) of service. Patient names and other identifying data are redacted.

I am maintaining **in my office** a list or other means to identify the patient, based on the number included in the log.

Within each log, I have identified any patients contained in the log who have experienced complications relating to my performance of surgery or special procedures in an office setting or licensed ambulatory care facility setting and their resulting outcomes.

As part of the application for privileges process, from the logs I am providing, at least 5 cases, **with personal identifiers redacted**, that are representative of the type of procedures for which I requested privileges will be selected and I will be asked to provide patient records (or pertinent portions), along with a completed case summary form for each.

DELINEATION OF PRIVILEGES

I have checked the column on the left of those privileges listed below to indicate those procedures for which I do not hold hospital privileges and for which I am requesting alternative privileges to perform these procedure(s) in the office setting.

Requested Privileges

_____	Placement of central venous catheter
_____	Insertion and revision of dialysis catheters, venous access devices and infusion pumps
_____	Insertion and revision of peritoneal dialysis catheters
_____	Injection of intravenous sclerosing solutions
_____	Other - Please specify and provide supporting documentation on a separate page:

I certify that my attestation of the number of procedures and any materials provided incident to this form (i.e. "supporting documentation") are true and accurate. I am aware that if any of the foregoing statements made by me or if the materials submitted by me are willfully false, I am subject to punishment.

Signature and printed name of Applicant

Date

Below this line for Administration Use Only

Licensee Name: _____ License Number: _____

Application Tracking Record

Initial Receipt Date of Application _____
Transmittal Date to Outsourcing Entity _____
Supplemental Information Requested _____
Supplemental Information Received _____
Outsourcing Entity Recommendation _____
Outsourcing Entity Reviewer _____
Board Committee Review Date _____
Board Disposition Date _____

Licensee Name: _____ License Number: _____